DOCUMENT RESUME

ED 418 518 EC 306 325

TITLE	Early Childhood Special Education for Children with Disabilities, Ages Three through Five: Evaluation and Assessment Guidelines for Young Children with Special Needs.
INSTITUTION	North Dakota State Dept. of Public Instruction, Bismarck. Div. of Special Education.
PUB DATE	1996-00-00
NOTE	45p.; One of three main sections contained in EC 306 324.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Compliance (Legal); *Disabilities; *Disability Identification; *Early Childhood Education; *Educational Assessment; Educational Legislation; Educational Practices; Eligibility; Evaluation Methods; Federal Legislation; Guidelines; Infants; Personnel; *Special Education; State Standards; *Student Evaluation; Young Children
IDENTIFIERS	Individuals with Disabilities Education Act Part H; *North Dakota

ABSTRACT

This chapter from a North Dakota guide for early childhood special education personnel focuses on the evaluation and assessment of young children with special needs. Following an introduction, which summarizes requirements under Part H of the Individuals with Disabilities Education Act, overviews of infant development and early childhood special education programs in North Dakota and the application of federal law are provided. A section on identification of young children with disabilities discusses the Child Find program, screening, evaluation for eligibility, assessment for program planning, timelines, and team process. Next, the evaluation/assessment planning process is outlined, including obtaining background information and developing the child profile, facilitating family involvement, and formulating an evaluation/assessment plan. Conducting the actual evaluation is discussed next and includes arena evaluation, play-based evaluation, and using parents and caregivers as a source of information. The final section is on report writing. Subsections explain the Infant Development Report, the Early Childhood Special Education Integrated Written Assessment Report, and the dissemination of information. Appendices include: strategies for professionals working with families from various cultural and/or linguistic groups; questions for professionals to ask when conducting a culturally sensitive screening and assessment; selected evaluation and assessment instruments for early intervention; types of test reliability and validity; and arena evaluation. (DB)

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ED 418 518

EARLY CHILDHOOD SPECIAL EDUCATION FOR CHILDREN WITH DISABILITIES, AGES THREE THROUGH FIVE: EVALUATION AND ASSESSMENT GUIDELINES FOR YOUNG CHILDREN WITH SPECIAL NEEDS

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Prepared By

North Dakota Interagency Coordinating Council
Evaluation and Assessment Subcommittee

Published By

ADAPTIVE SERVICES DIVISION
NORTH DAKOTA DEPARTMENT OF PUBLIC INSTRUCTION
Wayne G. Sanstead, Superintendent
1996

EC 306325

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Evaluation and Assessment Guidelines

for

Young Children with Special Needs

Evaluation and Assessment Subcommittee

North Dakota
Interagency Coordinating Council

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FOREWORD

The Evaluation and Assessment Subcommittee of the North Dakota Interagency Coordinating Council was established in the fall of 1992 to develop guidelines for the assessment of young children with special needs. The work of the subcommittee, which is represented by this document, covers both the Infant Development Program, administered by the North Dakota Department of Human Services, and the Early Childhood Special Education Program (ECSE), administered by the North Dakota Department of Public Instruction.

Creating one document that applies to both programs presented special challenges to the subcommittee due to inherent differences and legislation that supports each program. It is the expectation of the subcommittee members that this document will be useful as a resource and guide to assessment practices in infant and early childhood special education programs in North Dakota.

Mary McLean and Mary Stammen, Co-chairs

INTRODUCTION

Public Law (P.L.) 99-457 as re-authorized by P.L. 102-119 (known as Part H of the Individuals with Disabilities Education Act - IDEA) mandates each state system to ensure that each public agency establishes and implements procedures that meet the requirements for evaluation as identified in IDEA. Such evaluations must take place prior to initial placement of a child with disabilities in a program providing special education and related services. The evaluations must be timely, comprehensive, and multidisciplinary in nature. In addition, evaluation and assessment procedures should:

1. respect the unique developmental nature and characteristics of the child and his or her family,
2. include the active participation of parents and other significant caregivers,
3. be sensitive to cultural and ethnic differences, and
4. utilize appropriate assessment procedures and instruments.

OVERVIEW OF THE INFANT DEVELOPMENT AND EARLY CHILDHOOD SPECIAL EDUCATION (ECSE) PROGRAMS: FEDERAL LAW APPLIED TO NORTH DAKOTA

In North Dakota, early intervention services for children with disabilities ages birth through five and their families occur through state programs of two agencies, the Department of Public Instruction and the Department of Human Services. State formula grants for infants and toddlers with disabilities (Part H of Individuals with Disabilities Education Act - IDEA) and preschoolers with disabilities (Part B, Section 619 of IDEA) are used to facilitate the statewide systems developed to address these respective populations.

Although Part H and Part B, Section 619 are similar in intent and serve populations with similar needs, their focus differs. Part H of the law addresses service provision to infants and toddlers, with disabilities ages birth through 2 years. It views the family unit as the recipient of the service. The family centered-approach contained in Part H includes a provision for the assessment of family needs and results in an intervention plan addressing not only the needs of the infant with disabilities, but also the needs of the family unit. This plan is referred to as an Individualized Family Service Plan (IFSP). Part B, Section 619 of IDEA, addresses service provision to disabled children, ages three through five years. It is consistent with the approach used throughout the remaining sections of IDEA and includes a child-focused approach. The Individualized Education Program (IEP) is designed to provide intervention directed to the child. Although this section of the law also contains provisions for parent involvement, the family unit is not viewed as the recipient of the intervention.

The terminology contained in the two sections of the law relevant to the assessment process, also varies. This was necessitated by the differences in focus-family-focused versus child-focused.

In contrast to Part H, Part B regulations utilize the terms *identify*, *locate*, and *evaluate*. The terms *identify* and *locate* refer to child find, screening, and referral processes, while evaluation refers to all of the procedures used to determine whether or not a child has a disability and to identify the individual programming needs of the child.

Congress, in enacting Public Law 101-476 (IDEA), demonstrated the clear intent that all children in need of special services *be identified, located, evaluated and served*. The intent is further enhanced through strengthened coordination of child evaluation, assessment and services regulated under Part H and Part B. This promotes a seamless system of services for children with disabilities from birth through five years of age and their families.

North Dakota meets the federal intent with its unified approach for children ages birth through five. Various efforts have been initiated to establish a seamless system in North Dakota. One such effort has been the establishment of an

Under Part H, *evaluation* refers to the information gathered to determine eligibility, while *assessment* addresses the information gathered to determine intervention and support needs. The assessment process under Part H also specifically addresses family resources, priorities and concerns. In North Dakota, the term assessment process is used to encompass both evaluation and assessment activities for preschool and school-age populations.

Interagency Coordinating Council representing agencies serving children birth through five. Other efforts include the development of a state level interagency agreement among numerous agencies and programs serving children from birth through five, the development of transition agreements and procedures between infant development and early childhood special education programs, a community approach to selective screening, and the establishment of a regional North Dakota Early Childhood Tracking System -NDECTS).

These efforts have identified a set of tasks and opportunities immediately relevant to evaluation and assessment that need to be addressed and resolved in maintaining a statewide seamless approach. These tasks include:

- identifying young children with disabilities, ages birth-through 5 years of age;
- planning evaluation and assessment strategies for young children with disabilities using a multidisciplinary approach;
- conducting the evaluation utilizing parent input; and
- preparing a written report including an integrated summary.

The reader will notice that these tasks, with their unique programmatic differences, are addressed throughout each section of the document.

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IDENTIFICATION OF YOUNG CHILDREN WITH DISABILITIES

Identification of young children with disabilities can be undertaken for a multiple of purposes through various activities. Activities such as locating, screening, evaluating, and assessing can be distinguished as serving definite purposes in the identification of young children with disabilities. Each activity has a focused purpose and strategies for implementation, although the overall philosophy of evaluation and assessment will be consistent throughout all activities.

CHILD FIND

The term *Child Find* refers to North Dakota's system of procedures for locating children who are in need of early intervention. Child Find encompasses the age range birth through 21 years, although the emphases in this document is the birth through five year age range.

The Child Find system encompasses all efforts aimed at identification of children with disabilities including public awareness/education activities, screening programs, and interagency efforts. Education of the general public is an integral part of identification efforts.

The North Dakota Department of Human Services, through the Interagency Coordinating Council, Child Identification Subcommittee, has developed a campaign designed to supplement the activity of the Department of Public Instruction that targets families of children ages birth through five years. The purpose of this campaign is to educate parents and the general public regarding typical development in young children. The campaign is multifaceted and includes the development of a universal logo, brochures, and informational packets. The campaign material may be used by clinics, hospitals, public health centers, human service agencies, educational agencies, and early childhood programs. Implementation of the campaign is facilitated by the North Dakota Early Childhood Tracking System, which consists of teams of local and regional agencies serving children ages birth through five. (See Resources section of this document.)

Child Find is an ongoing process that operates on a daily basis rather than as a once or twice a year effort. The potential for locating unidentified children with disabilities is maximized through all public awareness and interagency collaborative efforts. Certain times during the year may be designated for special recognition of the Child Find system, as is the case during the third week in September when the Department of Public Instruction coordinates activities with local agencies in publicizing Child Find efforts.

Ongoing public awareness/education is critical to the success of Child Find procedures. Activities aimed at increasing public awareness of infant and early childhood special education services for children with disabilities may take many forms. Formats that may be used include the printed media, radio, television, and public presentations. The State Health Department operates a toll-free telephone number for individuals who have questions or concerns relevant to referrals. Ongoing planning and evaluation of public awareness/education efforts will ensure an effective Child Find system.

SCREENING

Community Screening. The purpose of screening is to identify children who may be in need of further assessment. Screening yields only a general evaluation of the child's functioning and answers the question, "Does a problem exist?" Because of reliance on gross estimates of performance, screening measures do not provide adequate information for eligibility or placement decisions.

Some community early intervention teams provide large-scale, community wide mass screening activities. These activities are sponsored for all children of a targeted age group within that community. Agencies commonly involved include public health, social services, and education. The targeted ages vary across communities. Some communities attempt to identify three year old children with disabilities; others screen those who are four years old. Some communities provide mass screening to all children who will be enrolling in kindergarten. Although special education personnel may be involved in these screening activities, they should be viewed as supplemental contributions to the community's responsibility. The mass screening cannot replace existing selective screening procedures and cannot be supported by federal funds earmarked for special education children.

Selective Screening. Selective screening is the process of screening only those children suspected of having a disability who are referred due to identified risk factors. This screening will determine the significance of the risk conditions to the child's growth and development or academic performance. The result of the screening process is a systematic collection of information for each child that helps determine whether there is a need for further evaluation by a multidisciplinary team.

In all cases, two procedures must be followed. First, parents must be notified that their child has been referred for screening and must provide written consent for the child to participate in the selective screening process. The notice must include a description of the concern, the procedures to be used, the date, time and location of the screening, and who will be involved (See *Guidelines: Parent Rights, Prior Notice, and Parent Consent Procedures,* July 1993). Parents must provide written consent for the child to participate in the selective screening process.

Second, parents must also receive a written summary of the screening results. The team that reviews the results of the screening will determine whether the child should be referred for a complete evaluation by school, other agency or medical personnel, should be re-screened at a later date, or does not need further evaluation. If the results of the screening indicate the need for an evaluation because of a suspected disability, parent consent must be obtained and an explanation of procedural safeguards given before proceeding with further evaluation and assessment.

Many agencies that provide services to young children (e.g., Head Start and Early Periodic Screening Diagnosis and Treatment (EPSDT) program), have responsibility for screening children ages birth through five years. Local programs are encouraged to work together to reduce duplication in screening activities for families by providing community or multi-agency screenings.

EVALUATION FOR ELIGIBILITY

The process of identifying children with disabilities consists of two components: evaluation and assessment. Part H regulations (IDEA, or 34 CFR §303.322 of Part H) define the evaluation process as separate from the assessment process. Part B regulations (IDEA, 34 CFR §300.-530) do not differentiate between evaluation and assessment; rather both are addressed under "Preplacement Evaluation" regulations.

As defined in IDEA, *evaluation* is the procedure used by appropriate qualified personnel to gather information that will be used to determine a child's initial and continuing eligibility, consistent with the legal definition of infants and toddlers or preschoolers with disabilities. Additionally, Part H includes in the definition the procedures for determining the status of the child in each developmental area. Evaluation can be described as a systematic process of collecting information on a child's health status, medical history, and current level of functioning, which is used in the determination of eligibility. **(IDEA, 34 CFR §303.322 of Part H, and IDEA, 34 CFR §300.530 of Part B)**

Table A1 presents a comparison of Part B and Part H language and requirements relative to evaluation and assessment.

For infants and toddlers ages birth through two years, information gathered through the evaluation process is compiled in a written report and presented to the regional Human Service Center Eligibility Determination Team. This team determines eligibility for Developmental Disabilities case management services. The information gathered from evaluation procedures is also used during the assessment process. When a child has been determined eligible for early intervention services, assessment procedures can be continued to identify child and family needs for intervention.

For children ages birth through two, the evaluation and assessment of each child must:

- be conducted by personnel trained to utilize appropriate methods and procedures;
- be based on informed clinical opinion;
- include a review of pertinent records related to the child's current health status and medical history;
- include an evaluation of the child's level of functioning in each of following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive skills;
- include an assessment of the unique needs of the child in each of the above developmental areas, including the identification of services appropriate to meet those needs.

(IDEA, 34 CFR §303.322 of Part H)

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Table A1. Comparison of IDEA Part B and Part H with regard to Evaluation and Assessment

IDEA 34 CFR §300.322 OF PART H
INFANT TODDLER, BIRTH THROUGH TWO YEARS

§303.322 Evaluation and assessment.

(a) General.
(1) Each system must include the performance of a timely, comprehensive, multidisciplinary evaluation of each child, birth through age two, referred for evaluation, including assessment activities related to the child and the child's family.
(2) The lead agency shall be responsible for ensuring that the requirements of this section are implemented by all affected public agencies and service providers in the State.

(b) Definitions of evaluation and assessment. As used in this part –
(1) "Evaluation" means the procedures used by appropriate qualified personnel *to determine a child's initial and continuing eligibility under this part, consistent* with the definition of "infants and toddlers with disabilities" in §303.16, including determining the status of the child in each of the developmental areas in paragraph (c)(3)(ii) of this section.
(2) "Assessment" means the ongoing procedures used by appropriate qualified personnel throughout the period of a child's eligibility under this part to identify –
(i) The child's unique strengths and needs and the services appropriate to meet those needs; and
(ii) The resources, priorities, and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their infant or toddler with a disability.

(c) Evaluation and assessment of the child. The evaluation and assessment of each child must –
(1) Be conducted by personnel trained to utilize appropriate methods and procedures;
(2) Be based on informed clinical opinion; and
(3) Include the following:
(i) A review of pertinent records related to the child's current health status and medical history.
(ii) An evaluation of the child's level of functioning in each of the following developmental areas:
(A) Cognitive development.
(B) Physical development, including vision and hearing.
(C) Communication development.
(D) Social or emotional development.
(E) Adaptive development.
(iii) An assessment of the unique needs of the child in terms of each of the developmental areas in paragraph (c)(3)(ii) of this section, including the identification of services appropriate to meet those needs.

(d) Family assessment.
(1) Family assessments under this part must be family-directed and designed to determine the resources, priorities, and concerns of the family related to enhancing the development of the child.
(2) Any assessment that is conducted must be voluntary on the part of the family.
(3) If an assessment of the family is carried out, the assessment must –
(i) Be conducted by personnel trained to utilize appropriate methods and procedures;
(ii) Be based on information provided by the family through a personal interview; and
(iii) Incorporate the family's description of its resources, priorities, and concerns related to enhancing the child's development.

(e) Timelines.
(1) Except as provided in paragraph (e)(2) of this section, the evaluation and initial assessment of each child (including the family assessment) must be completed within the 45-day time period required in §303.321(e).
(2) The lead agency shall develop procedures to ensure that in the event of exceptional circumstances that make it impossible to complete the evaluation and assessment within 45 days (e.g., if a child is ill), public agencies will –
(i) Document those circumstances; and
(ii) Develop and implement an interim IFSP, to the extent appropriate and consistent with §303.345(b)(1) and (b)(2). (Approved by the Office of Management and Budget under control number 1820-0550)
(Authority: 20 U.S.C. 1476(b)(3); 1477(a)(1), (a)(2), (d)(1), and (d)(2))

Note: This section combines into one overall requirement the provisions on evaluation and assessment under the following sections of the Act: (1) section 676(b)(3) (timely, comprehensive, multidisciplinary evaluation), and (2) section 677(a)(1) and (2) (multidisciplinary and family-directed assessments).

The section also requires that the evaluation-assessment process be broad enough to obtain information required in the IFSP concerning (1) the family's resources, priorities, and concerns related to the development of the child (section 677(d)(2)), and (2) the child's functioning level in each of the five developmental areas (section 677(d)(1)).

IDEA 34 CFR §300.530 OF PART B
PRESCHOOL THREE THROUGH FIVE YEARS

Before any action is taken with respect to the initial placement of a child with a disability in a program providing special education and related services, a full and individual evaluation of the child's educational needs must be conducted in accordance with the requirements of §300.532.
(Authority: 20 U.S.C. 1412(5)(C))

§300.532 Evaluation procedures.

State educational agencies and LEAs shall ensure, at a minimum, that:
(a) Tests and other evaluation materials –
(1) Are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so;
(2) Have been validated for the specific purpose for which they are used; and
(3) Are administered by trained personnel in conformance with the instructions provided by their producer.
(b) Tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient.
(c) Tests are selected and administered so as best to ensure that when a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (except where those skills are the factors that the test purports to measure).
(d) No single procedure is used as the sole criterion for determining an appropriate educational program for a child.
(e) The evaluation is made by a multidisciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of suspected disability.
(f) The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities. (Authority: 20 U.S.C. 1412(5)(C))
Note: Children who have a speech or language impairment as their primary disability may not need a complete battery of assessments (e.g., psychological, physical, or adaptive behavior). However, a qualified speech-language pathologist would (1) evaluate each child with a speech or language impairment using procedures that are appropriate for the diagnosis and appraisal of speech and language impairments, and (2) if necessary, make referrals for additional assessments needed to make an appropriate placement decision.

§300.533 Placement procedures.

(a) In interpreting evaluation data and in making placement decisions, each public agency shall –
(1) Draw upon information from a variety of sources, including aptitude and achievement tests, teacher recommendations, physical condition, social or cultural background, and adaptive behavior;
(2) Ensure that information obtained from all of these sources is documented and carefully considered;
(3) Ensure that the placement decision is made by a group of persons, including persons knowledgeable about the child, the meaning of the evaluation data, and the placement options; and
(4) Ensure that the placement decision is made in conformity with the LRE rules in §§300.550-300.554.
(b) If a determination is made that a child has a disability and needs special education and related services, an IEP must be developed for the child in accordance with §§300.340-300.350.
(Authority: 20 U.S.C. 1412(5)(C); 1414(a)(5))

Note: Paragraph (a)(1) of this section includes a list of examples of sources that may be used by a public agency in making placement decisions. The agency would not have to use all the sources in every instance. The point of the requirement is to ensure that more than one source is used in interpreting evaluation data and in making placement decisions. For example, while all of the named sources would have to be used for a child whose suspected disability is mental retardation, they would not be necessary for certain other children with disabilities, such as a child who has a severe articulation impairment as his primary disability. For such a child, the speech-language pathologist, in complying with the multiple source requirement, might use (1) a standardized test of articulation, and (2) observation of the child's articulation behavior in conversational speech.

§300.534 Reevaluation.

Each SEA and LEA shall ensure –
(a) That the IEP of each child with a disability is reviewed in accordance with §§300.340-300.350; and
(b) That an evaluation of the child, based on procedures that meet the requirements of §300.532, is conducted every three years, or more frequently if conditions warrant, or if the child's parent or teacher requests an evaluation.
(Authority: 20 U.S.C. 1412(5)(c))

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For preschoolers ages three through five years, the local school gathers information using the state assessment process for determination of a disability (see *Guidelines: Assessment Process*). This information, along further further assessment data, is used to identify further programming needs.

ASSESSMENT FOR PROGRAM PLANNING

Assessment is defined as the ongoing procedure used by appropriately qualified personnel throughout the period of a child's eligibility to identify the child's unique needs and the nature and extent of intervention services that are needed by the child and family. The outcome of assessment activities is the identification of special services needed by the child and family and the delineation of intervention objectives as specified in the Individualized Family Service Plan (IFSP) for children birth through two years of age, and the Individualized Education Program (IEP) for children who are three through five years of age. In the Infant Development Services, as indicated previously, the evaluation process will precede the assessment process. However, in Early Childhood Special Education Services, evaluation and assessment are included in the same process.

TIMELINES

Part H and Part B of IDEA identify specific, but different, timelines for the completion of certain activities when a child is being evaluated and assessed. Under Part H, a referral source has two working days to refer a child to the regional Human Service Center. The evaluation, assessment, and the Individualized Family Service Plan (IFSP) must be completed within 45 days of the referral to the Human Services Center. This timeline is to protect children and their families from undue delay that could be harmful and to make the process responsive to families. If an initial or interim IFSP is postponed beyond the 45 days at the request of the family, this should be documented by the service coordinator and is acceptable under the law. However, a postponement due to a shortcoming on the part of the service delivery system is legally unacceptable.

Part B states that a public agency has 30 days from point of determination of a disability to hold a meeting to develop the written Individualized Education Program (IEP) for a child. Service must begin "as soon as possible" following the IEP meeting. Although federal regulations do not address the time span between date of referral and completion of the evaluation, the North Dakota Department of Public Instruction recommends that the evaluation be completed within 30 days from receipt of the referral. In exceptional circumstances, such as when the child/family cannot be reached, the total assessment process may go beyond the specified timeline. To justify this extended timeline, public agencies must document the circumstances that make meeting the deadline impossible. Upon completion of the assessment process and determination of a disability, an IEP is developed. At the conclusion of the IEP, a placement decision will be made and the child may begin receiving special education services, if appropriate. If further assessment needs are identified, additional information can be gathered and the results considered in revision of the IEP as appropriate.

Table A2 summarizes the location, identification, evaluation and assessment process for young children.

TABLE A2. The Process of Location, Identification, Evaluation and Assessment of Children, Birth Through Five, Who Are Eligible for Services

Activity	Purpose	Personnel	Activities
Child Find	To create awareness of typical and atypical child development among the general public	State personnel, public health professionals, volunteers, community members, early childhood personnel, parents, caregivers	Census taking, posters, brochures, media publicity, referral to tracking
Selective Screening	To identify children suspected of having a disability who may need further diagnostic assessment	Professionals, parents, paraprofessionals	Administration of screening instruments, medical screenings/examinations, hearing and vision testing, parent questionnaires, and review of records
Evaluation for Eligibility	To determine existence of delay or disability.	Multidisciplinary team of educators, psychologists, parents, clinicians, physicians, social workers, therapists, nurses, caregivers	Formal and informal testing, parent interview, home or school observation, team meetings
Assessment for Program Planning	To determine/identify child and family strengths and needs, individual education/family services needed intervention activities, and awareness of program setting options.	Parents, teachers, assessment team personnel, other professionals	Home and/or program observation, informal assessment, development of intervention objectives

Adapted from Meisels and Provence (1989)

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TEAM PROCESS

Both Part B and Part H require that evaluation and assessment be multidisciplinary team efforts. The manner in which team members organize themselves to accomplish the evaluation is most important. Best practice suggests that evaluation should be a collaborative team process. The individuals involved should coordinate their efforts and function as a team rather than as separate individuals. The family is an integral part of the team.

Multidisciplinary Model. According to IDEA, "multidisciplinary means the involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities." (IDEA, 34 CFR §303.17 of Part H). Variations of this model of team functioning that have been recommended for early intervention include both the interdisciplinary and transdisciplinary model.

Interdisciplinary Model. Under the interdisciplinary model the child is assessed individually by members of several disciplines. A meeting is then held so that the evaluation summary and recommendations will reflect a team consensus.

Transdisciplinary Model. Under the transdisciplinary model, the child is evaluated simultaneously by multiple professionals. A common sample of behavior is the basis from which all members of the team complete the evaluation. A team meeting is held to formulate an integrated report that represents the consensus of the team.

The transdisciplinary team approach is a model that is highly recommended for evaluation and assessment of young children. Further information on this approach can be found in the section conducting the Evaluation and in Appendix E.

Training for those who serve on evaluation/assessment teams for young children must include the skills necessary for coordinated, informed teamwork. One single source of information and/or expertise cannot provide a complete picture of the young child's characteristics. It is essential that professionals develop the skills necessary to work along with the family as members of a team.

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EVALUATION/ASSESSMENT PLANNING PROCESS

The purpose of an evaluation/assessment plan is to identify questions that will assist in the determination of whether a child has a disability as well as to describe the child's unique needs. Planning should also incorporate the family's priorities and concerns.

The evaluation/assessment plan cannot be developed by one individual. Input must be obtained from persons who, because of their expertise or their relationship or position in the child's life, can observe, gather data, and evaluate all aspects of the child's functioning. The plan will be developed by the evaluation team that is composed of the family and professionals from each of the disciplines from which information is needed about the child's development and current level of functioning.

The steps involved in evaluation/assessment planning include:

- obtaining all background information to develop a child profile;
- determining family goals and involvement for evaluation/assessment; and
- formulating the evaluation/assessment plan.

BACKGROUND INFORMATION/ CHILD PROFILE

The team should begin the process by gathering all pertinent information already known about the child by each of its members. With this information, the team will develop a profile of the child. Information can be gleaned from a variety of sources including health records, teacher reports, information from a cumulative file, and parent information. In addition, those factors that precipitated the referral should be noted as a significant part of the child's profile. Evidence of abilities and strengths as well as patterns of weakness provide information relevant to a child's developmental pattern, but the same information raises new questions as well. Such information reflects the child's learning characteristics and will provide direction for the evaluation plan. Early Childhood Special Education Services will follow reference guides put forth by the Department of Public Instruction (see *Guidelines: Assessment Process*).

FAMILY INVOLVEMENT

Family Involvement in the Planning Process. Family involvement assumes a partnership between the family and the professionals serving that family. For the partnership to be successful there must be an understanding that each member will contribute to the final outcome in a different way, and each contribution will be valued. Family involvement will differ with each family based on the family's perception of their role, the knowledge level of the family regarding child development, and cultural factors. For example, many American Indian families prefer to involve the grandparents and other extended family members in the evaluation process.

Family involvement in the evaluation planning process is very important. The evaluation process itself, as well as the test instruments and procedures selected, should be based on input from the family. Families should be invited to

contribute information to the planning process in the following areas:

- questions or concerns family members have about the child's development;
- preferred times and locations for the evaluation (i.e., times when the child will be most alert and locations where the child will be most comfortable);
- special toys or materials which might help in comforting or motivating the child; and
- the manner in which the family members would like to be involved (i.e., participating in the evaluation by holding the child; providing information to the team about the child's behavior, etc.).

When the evaluation procedures and instruments have been identified, the family should be fully informed about the instruments that will be used and the procedures to be followed. The family can greatly facilitate the evaluation by making sure the child is comfortable and by providing the team with information. To assist in the evaluation process, however, the family must be informed about what to expect during the evaluation. Options should be presented giving the family suggestions on how they might become involved. Families should then be allowed to determine the extent of their involvement in the evaluation process. Some families may opt for a family-directed process in which they have a leadership role, whereas others may prefer a collaborative process with shared decision-making.

Assessment of Family Concerns, Resources and Priorities. Under Part H, the family will be involved in an assessment to identify the resources, priorities, and concerns of the family that relate to enhancing the development of the child. This assessment must be voluntary on the part of the family and must be directed by the family. Personnel involved should be trained to conduct the assessment through a family interview process.

It is suggested that family members be invited to share their concerns about the child's development during the evaluation process to determine eligibility. More indepth information on family priorities for intervention and resources related to enhancing the child's development may be obtained during the assessment process as information is gathered to plan intervention.

FORMULATION OF AN EVALUATION/ ASSESSMENT PLAN

The evaluation process is utilized to gather and synthesize information for a variety of purposes. Although in the past a disproportionate emphasis was placed on evaluation for program eligibility purposes, the focus appears to be shifting to include a more comprehensive model of assessment. Areas that should receive equal emphasis include evaluating program implementation variables such as how the child learns best, what is reinforcing to the child, and whether the child maintains and generalizes skills. Ecological variables include family support needs and community environments to include as settings for service. Instructionally relevant information that should be determined through the evaluation process consists of problem solving strategies the child has learned to utilize, psychological processing strengths and

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discrepancies, responsiveness to instructional styles and materials, and the child's learning curve. Other topical areas might consist of curriculum referenced assessment across domains, effectiveness of prior interventions, responsiveness to intervention techniques and formats, efficacy data collection, and program evaluation.

Considering the potential comprehensiveness or scope of an evaluation process, it is important to articulate clear purposes for individual evaluations. When evaluation/assessment is to determine whether the child has a disability, one of the purposes must be to obtain relevant child data for this decision. Actual benefits of child evaluation, however, are much broader. Even those children who are determined not to have a disability will benefit from the process since information obtained may lead to other services that might be provided.

In the evaluation planning process, questions regarding the child's development will be formulated. Questions should relate to the suspected disability, the child's style of learning and the learning environment. It is also important to focus questions on the areas of health, social-cultural background, sensory functioning, and emotional development to assure non-biased assessments. The more specific the questions are, the greater the likelihood that assessment procedures will be selected that will provide developmentally and educationally relevant data. Based upon the questions asked, the team constructs a plan for gathering relevant information and outlines specific procedures to be followed in gathering the information. The list of questions that have been formulated and still need to be answered will also determine who will gather the data, and whether additional persons need to be added to the evaluation team.

The content of the evaluation plan will be determined by the kind of data already available and the information that still needs to be gathered. The assessment plan will vary from child to child. In addition, the range of concerns reported, the complexity of those concerns, and the age of the child will determine the type and amount of evaluation required. If during the evaluation process the team determines that information in any area is incomplete, a plan to gather the missing information should be outlined and carried out as part of the assessment process. Skillful and careful observations are required to recognize clues in the child's performance signaling that not all of the pertinent information is known.

For children ages three through five, the team's plan must be documented. A written plan will become a working document for each team member and will serve as a reference for accountability purposes. The *Guidelines: Assessment Process* document prepared by DPI should be followed by preschool teams.

The evaluation planning process will culminate in a written document that specifies instruments and procedures to be used, family members, caregivers and professionals to be involved, toys or other materials to be used, and the location and times for conducting the evaluation. It's important to remember that evaluation and assessment planning is an ongoing process because new questions may arise during evaluation which call for additional procedures.

In deciding on the instruments and procedures to be used, the team will review the background information available on

the child and consider the questions and concerns identified by the family and the professionals on the team. Specific instruments and procedures will be individually selected to determine whether the child has a disability and to answer the questions that have been identified.

There are at least three other aspects of evaluation which should also be considered at this time:

- evaluation and assessment procedures must be nondiscriminatory;
- instruments and procedures used should be reliable and valid; and
- evaluation procedures should be culturally appropriate.

Each of these aspects will be discussed below.

Nondiscriminatory Procedures. Each state agency is required to adopt nondiscriminatory evaluation and assessment procedures for children birth through five years of age.

The law requires that tests and other evaluation materials:

- be provided and administered in the child's native language or other mode of communication;
- be validated for the specific purpose for which they are used;
- be administered by trained personnel in conformance with the instructions provided by the producer of the materials;
- include instruments tailored to assess specific areas of educational needs, and not merely those that are designed to provide a single general intelligence quotient; and
- be selected and administered to best ensure that when a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level, or whatever other factors the test purports to measure, rather than simply reflecting the child's disability (except, of course, in cases in which the effects of the disability are the specific factors that are being measured).

No single procedure may be used as the sole criterion for determining an appropriate educational program for a child, and the evaluation must be done by a multidisciplinary team that includes at least one specialist with knowledge in the area of suspected disability. Additional information is contained in Appendix A and B.

Reliability/Validity. Standardized and criteria-referenced or curriculum-referenced tests should have been developed by test publishers through a process of development, field-testing, and refinement. Unfortunately, some instruments are published and advertised which have not been adequately field-tested. Therefore, the professional must be skilled in judging the quality of instruments and knowledgeable about the characteristics of the instruments used.

Tests are typically evaluated according to reliability and validity. (Refer to Appendix D for information on reliability and validity.) A test is *reliable* if it consistently yields the same or similar results. A test is *valid* if it actually measures what it purports to measure.

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Culturally Sensitive Evaluation. Richard N. Roberts in the *Workbook for Developing Culturally Competent Programs for Families of Children With Special Needs* (1990), views cultural competence as "a program's ability to honor and respect those beliefs, interpersonal styles, attitudes, and behaviors both of families who are clients and the multicultural staff who are providing services" (page 1). This well-rounded definition takes into account influences of both the family and the service provider and will be used throughout the following discussion focusing on evaluation and assessment as a process that is culturally sensitive.

The influence of the culture on family functioning and child rearing practices is not easily separated from the impact of a disability on a child and family members. Family members often can best identify how a child functions in a variety of natural settings and can describe the impact of the child's disability on skill acquisition and general growth and development. Eliciting this information often becomes pivotal in facilitating the gathering of comprehensive information about the child. This becomes more complex when the family is of another culture.

The evaluation and assessment process, therefore, must acknowledge and recognize the critical roles of the family and their cultural and linguistic background. Cultural variables to be acknowledged include:

- language and communication in the home, such as who speaks what language, when, and for what purpose;
- child rearing practices of the family;
- how family is defined within a particular culture; and
- cultural beliefs regarding what is considered healthy and what is considered a disability.

The cultural effects on a child's learning style, values, and self-concept must also be taken into account.

Children with multicultural backgrounds often appear to be acculturated to the dominant culture. However, they may have multiple cultural biases that are masked by the influences of the dominant culture. It is important to understand how closely the family is adhering to and is influenced by a traditional culture. Even when the child shows adequate use and understanding of the dominant culture, one must consider the amount of experience and practice the child/family has had with the dominant culture in relation to their traditional culture.

Standardized assessment tools are not normed to accommodate diverse cultural populations. Use of such instruments is extremely limited and fails to reflect accurate developmental information for those from diverse backgrounds. Modifications of standardized tools negates the norming value of the tools, making them situation specific. Information gathered from formalized tests, to be valuable, must be reinforced and augmented by other information gathering methods.

For diverse populations, evaluation and assessment cannot be defined merely as gathering standardized information that can be used to project future growth and development. To most adequately identify the special needs of a child and his/her family, the process must be unique

to the situation. Within this context, the assessment approach becomes an individualized, comprehensive view of the child's environment, rather than being an exercise in formal testing. This approach to evaluation and assessment, because of its individualized nature, will promote the use of developmentally appropriate practices throughout the process.

When a myriad of family and cultural factors are evident, evaluation/-assessment planning is imperative and vital in making the process culturally sensitive. Planning activities include a thorough analysis of background information, observations in the natural setting, interactions with culturally significant others to determine what adaptations and modifications will provide accurate information regarding other possible culturally relevant factors that may affect the assessment of the child and family.

Accurate information for the previously mentioned areas may be gathered in one or more of the following ways:

- talking directly to individuals of a particular culture;
- reviewing written material pertaining to certain cultures;
- observing family interactions and activities; and
- participating in other cultural activities.

Professionals need to accept that their understanding of culture is influenced by their own basic core beliefs and values. Every individual is rooted in a culture that sets core beliefs and values and serves as the primary influencer of attitudes toward other cultures. To effectively work with other cultures, not only must one neutralize one's own biases, but gather actual information about other cultures, discarding stereotypes and biased beliefs.

To establish credibility within the minority culture, the professional must become culturally competent, accept parents as equal team members and advocates for their child, and show a strong belief in a truly integrated society with equal opportunity for all. One must show a genuine sensitivity to and appreciation for the uniqueness of each child, the child's family and their needs. In doing so, communication between the cultures is enhanced and respect from the minority culture attained.

On an individual basis, professionals will need to evaluate their own level of cultural competence. To do so, the following questions must be critically pondered.

- To what extent do I accept and value diversity of beliefs, behavior, and values?
- Do I have the capacity for cultural self-assessment?
- To what degree am I aware of the dynamics that occur when cultures interact?
- How much cultural knowledge have I gained or do I have for the minority cultures with which I interact?
- What adaptations have I developed to accommodate diversity when working with young children and their families?

The answers to these questions will give insight into how impartial and unbiased one's system is for working with others from diverse backgrounds.

There may be times when, due to circumstances or limited cultural competence, it may be beneficial to use cultural mediators or interpreters. Often they are better able to make language adaptations during communication efforts, and they may be able to gain a sense of the proficiency the child holds for both languages to which he/she may be exposed. Interpreters or cultural mediators are often viewed as neutral by the family, gain the family's trust quickly, and establish a good working relationship with the family.

Appendix A of this guidebook is a fact sheet entitled "Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups." The ten strategies discussed will assist professionals in working effectively with children and families of other cultures.

Appendix B of this guidebook is a fact sheet entitled "Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment." The ten questions will assist professionals in making the screening and assessment process culturally sensitive.

CONDUCTING THE EVALUATION

> *"The best way to understand the development of children is to observe their behavior in natural settings while they are interacting with familiar adults over a prolonged period of time" (Bronfenbrenner, 1977).*

The above statement should serve as a guide for conducting evaluation and assessment procedures with infants, toddlers and preschoolers. Although standardized instruments may need to be used, the child's involvement should be as natural and nonthreatening as possible. Procedures that can facilitate this process are the arena evaluation, play-based evaluation, and using parents and caregivers as a source of information.

ARENA EVALUATION

Arena evaluation is the simultaneous evaluation of the child by multiple professionals of differing disciplines (Foley, 1990). This procedure is representative of a transdisciplinary model of team functioning. An example is when a physical therapist, an occupational therapist, an educator, and a speech therapist all evaluate the child simultaneously. Instead of each professional working with the child separately, the team of professionals works together with the child observing a common sample of behavior and immediately sharing expertise and information. The rationale for arena evaluation is based on the relative difficulty of separating physical, cognitive and sensory domains of development in the young child. The advantages of this approach extend to everyone involved - child, family and professionals. Since all professionals are working together, the amount of actual time spent in evaluation by the child and family is reduced. Family members can provide information once rather than possibly having to provide the same answers to each professional in turn. Professionals have the advantage of immediate access to the skills and knowledge of their teammates. In addition, consensus building is facilitated since a common sampling of behavior has been the basis of evaluation for all team members. Further information on arena evaluation is included in Appendix E.

PLAY-BASED EVALUATION

Procedures have also been identified for evaluation procedures based on observation of the child in more informal, play-based situations. Toni Linder has developed a system for evaluating child functioning across developmental domains in an arena format which involves the child in informally structured activities. *The Transdisciplinary Play-Based Assessment* (TPBA) method (Linder, 1990) relies on clinical observation and interpretation of these observations by the team of professionals to determine eligibility and to guide the development of the IFSP or IEP. The TPBA provides useful guidelines for the clinical observation of child behavior and may be used in addition to other instruments.

PARENTS AND CAREGIVERS AS A SOURCE OF INFORMATION

In recent years, there has been increased interest in involving family mem-

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bers and caregivers in the evaluation and assessment process. The importance of involving families in decision-making is emphasized in the most recent legislation - P.L. 99-457 and P.L. 102-119. Professionals also realize the importance of gaining information from the family about the child's behavior in a variety of situations.

Information from family members and caregivers can be obtained by interviews or by asking parents or caregivers to complete standardized measures, rating scales, or checklists. Many pre-screening instruments, such as the Infant Monitoring Questionnaire (IMQ) (Bricker, 1987), are completed by parents. The recently published *Ages and Stages* (Bricker, 1995), which is used for program planning, includes a scale called The Family Report which is completed by families.

WRITING THE REPORT

Upon the completion of the evaluation/ assessment process, the team will jointly develop a written integrated summary. The purpose of the written report may differ between infant development and early childhood special education programs; however, a thorough and complete written integrated report is necessary to ensure an appropriate interpretation of the assessment information.

The written integrated summary should be written in terms families can understand. If educational or medical terms must be used, definitions should be given. The summary should include:

- identifying information;
- reason for referral and referral source;
- medical and developmental history;
- evaluation/assessment procedures;
- interpretation of evaluation/assessment results; and
- conclusions including statement of disability and need for specialized instruction.

INFANT DEVELOPMENT REPORT

At the conclusion of an assessment of infants and toddlers with disabilities, an evaluation report will be written and forwarded to the Regional Human Service Center Eligibility Determination Team. This team determines eligibility for Developmental Disabilities Case Management System Services which may include Infant Development Services if the parent chooses. In the written report the evaluation team will make a recommendation regarding services in the infant development program. It is necessary for the report to include a rationale for this recommendation based on both qualitative and quantitative information derived from the evaluation. Information regarding a physical or mental diagnosis and a percentage of delay in any of the five developmental domains (cognition; receptive and expressive communication; gross and fine motor, physical; social-emotional; or adaptive)) must be included in this report.

Other issues that may not be directly related to eligibility determination may also be addressed in the evaluation process. For instance, information that would be helpful in planning the intervention program should be included. Furthermore, questions about the child's functioning that may have been identified during evaluation and require further assessment should also be included.

The evaluation report should be the result of team discussion. Information from tests, observations and interviews should be synthesized to present a comprehensive picture of the child's needs.

The term "informed clinical opinion" is part of the regulatory requirements of eligibility determination under Part H. The use of informed clinical opinion refers to the process of making a clinical judgment in those cases where test scores do not provide a comprehensive picture of a child's development. It is used as a safeguard against eligibility that is determined solely on test scores or isolated information. Informed clinical opinion is used by the evaluation team to make a

recommendation relative to eligibility for services. It makes use of qualitative and quantitative information in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention. The training and previous experience of the evaluation team, including the parents, form the basis for assuring an informed clinical opinion in the evaluation process. According to the National Early Childhood Technical Assistance System, cited in Biro, Daulton and Szanton (1991), this opportunity to integrate observations, impressions, and evaluation findings of the team facilitates a "whole child" approach to evaluation and assessment that goes beyond a reporting of test scores. In this way, the functional impact and the implications of noted delays or differences in development can be discussed and considered by the team in determining eligibility and developing the intervention plan.

Adjusting for Prematurity. When Infant Development Program staff are evaluating an infant who was born prematurely, the child's chronological age is adjusted to reflect the expected date of birth rather than the actual date. This adjustment is made if the infant is born more than four weeks prematurely and continues to be made until the chronological age of twelve to eighteen months (based on actual date of birth).

EARLY CHILDHOOD SPECIAL EDUCATION INTEGRATED WRITTEN ASSESSMENT REPORT

The team will write a report that integrates findings from all sources. The report will verify agreement that all current data have been gathered to make disability determination decisions. The integration of all assessment data ensures that attention has been given to observations and other information shared by each team member. In addition, the integration process protects the child from being labeled inappropriately. Decision-making by one person or on the basis of one procedure or situation increases the chance of inappropriate labeling and is prohibited by regulations. The report needs to be written in a manner that is understandable to parents and other professionals; a reiteration of test scores is not meaningful to parents and others.

Each of the areas listed below should be considered during the team's analysis of the assessment findings and is discussed further in the pages that follow:

- determination of disability;
- input from all assessment team members that reflects all areas of the child's functioning;
- observational information relating to child's learning;
- impact of disability on education;
- nondiscriminatory procedures;
- relationship between the assessment summary and strategies for individual program development;
- attention to immediate needs;
- signatures of all team members/ agreement; and,
- statement of disagreement (if applicable).

Determination of Disability. At the conclusion of the meeting to review the assessment results, the team will determine whether the unique educational needs of the child are due to a disability as defined by IDEA or Section 504 of the Vocational Rehabilitation Act of 1973. The report must include a statement as to whether the child has a disability and what that disability is as defined in IDEA or Section 504. The categories used in North Dakota are: specific learning disability, hearing impairment, deafness, visual impairment including blindness, deaf-blindness, mental retardation, serious emotional disturbance, orthopedic impairment, other health impairment, traumatic brain injury, autism, and speech or language impairment. If the child is not eligible under IDEA, the assessment report will determine if the child is considered "handicapped" under Section 504 of the Vocational Rehabilitation Act of 1973. This assures the provision of parental rights, procedural safeguards, and an individual accommodation plan, which are afforded under Section 504.

Section 504 applies to preschoolers when:

- they are enrolled in a Head Start program
- they are in a kindergarten program
- the public school sponsors a program for all 3, 4, or 5 year olds.

For children not requiring special education or services under Section 504 but for whom the existing regular education curriculum has not fostered successful learning, the school will need to plan for satisfactory changes in the regular educational program.

The written findings need to reflect the relationship of observational information to the child's learning/functioning. At least one professional other than the child's regular teacher shall observe the child's performance in the preschool setting or in an environment appropriate and familiar to the child, such as home. A summary report based on team analysis ensures that observations are not only recorded and shared but that attention is given to the effect these observations have on the child's ability to process information, express an idea, or perform a skill. Since observational data may either support or conflict with conclusions based on other assessment procedures, the inclusion of such data is critical.

An integrated written report enables all assessment team members, including the parents, to know whether the observation and other assessment information that they shared was considered. A child's unique patterns of functioning, particularly for children whose problems are complex, will emerge only after the team's joint analysis of *all* input rather than individuals drawing conclusions in isolation.

The conclusions drawn by the team are derived from the assessment data and recorded in the written report. Input from all assessment team members and all parameters of functioning must be considered. If some interfering factors are due to disabilities in addition to the *primary* disability, the written report ensures that such secondary disabilities are identified and addressed.

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Assessment findings from evaluators outside the school district or special education unit should be given equal consideration. Their findings should be discussed by the team in conjunction with all other findings and integrated into the written report. All information gathered during the assessment process is important, whether conducted by school personnel or outside evaluators.

Evaluation data generated by Infant Development Programs should be utilized. The transition process (see section on transition) addresses the roles of multiple agencies during the evaluation process or the transition from Infant Development to public school preschool programs.

Nondiscriminatory Procedures. Careful consideration should be given to nondiscriminatory assessment procedures to assure that the child is not identified as having a disability when the child's educational concerns are primarily related to cultural, environmental, sensory, or economic issues. These considerations must be included in the written report so that they can be considered when making decisions regarding the determination of disability.

Information for Program Development. The integrated written assessment report should serve as a resource document for all planning teams. Recommendations regarding instructional needs may be included in the report as further explanation of the child's performance within areas of strength or need. Such recommendations may be implemented regardless of whether there is an identified disability.

The report will not establish whether special education or related services are required or who is responsible for any resulting services; it will only determine whether the child has a disability and if it is appropriate to develop an IEP. *It is important to remember that when a child has been determined to have a disability, the IEP process (rather than the assessment process) determines whether the child in is need of special education and related services.* When the assessment findings have been adequately analyzed by the assessment team and the significant information summarized in the report, the IEP team will be able to draw directly from the report in preparing the present level of functioning statements for the IEP.

It is important to provide immediate attention to areas in need of modifications or adaptations that may not be relevant to eligibility or placement decisions. Examples of such situations are given below.

- Medical and other health-related problems as well as environmental circumstances that are physically threatening or otherwise affect a child's physical well-being need to be addressed. Response to such needs often requires a referral to specialists or other agencies.

- Classroom situations that impair learning or achievement and require attention regardless of placement can be addressed immediately. For instance, if a hearing impairment is reported and preferential seating is necessary, a change in seating arrangement should not be delayed until the development of the IEP. Any immediate changes implemented at this time will benefit the child and be advantageous to the assessment and program planning process.

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- The assessment report should indicate needs that are specifically setting-related. Examples include: physical accessibility; distractions (e.g., auditory, visual, spatial) that interfere with functioning; teacher style; classroom climate; number of personnel with whom the child will be expected to relate; and number and age of children in classroom. When assessment shows that setting-related factors make a critical difference, the observations should be noted in the report.

The sharing and analysis of the assessment data occur separate from and preceding the IEP meeting. However, procedures in local schools may be such that many of the same persons function on the multidisciplinary team for both assessment and IEP development. If so, the sharing and analysis of assessment information may precede IEP development during the same meeting.

Consensus Statement. The team needs to gain consensus on how all findings, including those from evaluators outside the district or special education unit, relate to the questions asked during the assessment planning process as well as if there is a significant impact on the child's learning. The procedures require that team members sign the report to verify that the report reflects their conclusions. If a team member disagrees with the report, that team member must attach a dissenting statement to that effect.

DISSEMINATION OF INFORMATION

Immediate feedback should be given to the family following an evaluation or assessment, if possible. A face-to-face conference at a later time would be an alternative as would a telephone conference. A last choice would be a letter to the family reporting results. The first two alternatives allow questions to be answered and misconceptions to be resolved. Every effort should be made to respond to the family's questions with honesty and conciseness and without the use of educational or medical jargon. The child's family should be made aware of the factors that form the basis for making a recommendation.

Personally identifiable information concerning a child, the child's parent, or other family members is confidential. Program staff must receive parental consent before sharing information about the family and the child with other agencies or professionals in private practice unless authorized to do so under the Family Educational Rights and Privacy Act.

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APPENDICES

APPENDIX A

APPENDIX A-A. Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups

APPENDIX A-B. Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment

APPENDIX A-C. Selected Evaluation and Assessment Instruments for Early Intervention

APPENDIX A-D. Types of Test Reliability and Validity

APPENDIX A-E. Arena Evaluation

APPENDIX A-A

Strategies for Professionals Working with Families from Various Cultural and/or Linguistic Groups

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1. Individualize the screening and assessment process for parents as well as for children. Children and other family members may be at various levels of acculturation and may require similar or varying degrees of modifications, adaptations, or support, such as language interpretation.

2. Do a self-assessment of your own cultural background, experiences, values, and biases. Examine how these factors may impact your interactions with people from other cultural groups.

3. Begin the screening and assessment process with the parents - their concern, reasons for coming to you, and expectations of what you can provide.

4. Take time to establish the trust needed to fully involve the family in the screening and assessment process.

5. Use bilingual and bicultural staff, or mediators and translators whenever needed. Try to maintain a consistency of providers to allow the family to establish an ongoing communication.

6. Allow for flexibility of the process and procedures. Meet with parents at their job site, or call them when they return home from their job, if necessary. Modify test items to ensure cultural relevancy.

7. Conduct observations and other procedures in environments familiar to the child. These may be at the home of his/her grandmother, outdoors, or at the parents' work site.

8. Provide assistance and be flexible in establishing meetings with parents. This might include providing for childcare of the siblings, transportation to a meeting site, or meeting the family in their home.

9. Participate in staff training on cultural competence skills in screening and assessment. Strive to achieve standards for professional cultural competence.

10. Conduct ongoing discussions with practitioners, parents, policymakers, and members of the cultural communities you serve.

APPENDIX A-B

Questions for Professionals to Ask When Conducting a Culturally Sensitive Screening and Assessment

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1. With what cultural group was this screening or assessment tool normed? Is it the same culture as that of the child I am serving?

2. Have I examined this screening and assessment tool for cultural biases? Has it been reviewed by members of the cultural group being served?

3. If I have modified or adapted a standardized screening or assessment tool, have I received input on the changes to be certain is it culturally appropriate? If using a standardized tool or one to which I have made changes, have I carefully scored and interpreted the results in consideration of cultural or linguistic variation? When interpreting and reporting screening and assessment results, have I clearly referenced that the instrument was modified and how?

4. Have representatives from the cultural community met to create guidelines for culturally competent screening and assessment for children from that group? Has information about child-rearing practices and typical child development for children from that community been gathered and recorded for use by those serving the families?

5. What do I know about the child-rearing practices of this cultural group? How do these practices impact child development?

6. Am I aware of my own values and biases regarding child-rearing practices and the kind of information gathered in the screening and assessment process? Can I utilize nondiscriminatory and culturally competent skills and practices in my work with children and families?

7. Do I utilize parents and other family members in gathering information for the screening and assessment? Am I aware of the people with whom the child spends time, and the level of acculturation of these individuals?

8. Do I know where or how to find specific cultural or linguistic information that may be needed for me to be culturally competent in the screening and assessment process?

9. Do I have bilingual or bicultural skills, or do I have access to another person who can provide direct service or consultation? Do I know what skills are required of a quality interpreter or mediator?

10. Have I participated in training sessions on cultural competence in screening and assessment? Am I continuing to develop my knowledge base through additional formal training and by spending time with community members to learn the cultural attributes specific to the community and families I serve? Is there a network of peer and supervisory practitioners that is addressing these issues, and can I become a participating member?

APPENDIX A-C

SELECTED EVALUATION AND ASSESSMENT INSTRUMENTS FOR EARLY INTERVENTION

Developmental Screening

Assessment Instrument	Domains/ Component	Age	Description	Publisher
Battelle Developmental Inventory Screening Test	Personal-social Adaptive Motor Communication Cognitive	birth - 8 years	Nationally standardized screening test; abbreviated version of full scale	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Denver Developmental Screening Test - Revised (DDST)	Gross motor Fine motor Personal-social Language	1 month - 6 years	Screening instrument that assesses 4 areas (including a pre-screening form)	DDM, Inc. PO Box 20037 Denver, CO 80220
Minnesota Preschool Inventory	Developmental Scales Adjustment Scales	2 - 6 years	Screening instrument profiles current functioning levels	Behavior Science PO Box 1108 Minneapolis, MN 55440
Developmental Indicators for the Assessment of Learning - Revised (DIAL-R)	Gross motor Fine motor Concepts Communication	2 1/2 - 5 1/2 years	Standardized; identifies potential learning problems	Mardell-Czudnowski & Goldenberg Childcraft Education Corp. Edison, NJ 08818
Comprehensive Identification Process (CIP)	Cognitive-verbal Motor Language Sensory Social Medical history	2 1/2 - 5 1/2 years	Standardized; identifies potential learning problems in children in need of special services	Scholastic Testing Services 480 Mayer Road Bensonville, IL 60106
Developmental Activities Screening Inventory, II (DASI)	Fine motor Initiative behavior Identification Classification Matching Number concepts Response to commands	6 months - 5 years	Assesses sensory motor behavior across 55 uncategorized developmental tasks	Testing Resources Corp. 50 Pond Park Rd. Illingham, MS 02025
Developmental Profile II	Physical Self-help Social Academic Communication	birth - 12 years	Estimates current level of performance in 5 areas	Psychological Development 7150 Lakeside Dr. Indianapolis, IN 46278

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APPENDIX A-C (continued)

Standardized Developmental and Intellectual Assessments

Assessment Instrument	Domains	Age	Description	Publisher
Wechsler Preschool and Primary Scales of Intelligence (WPPSI)	Verbal Skills Performance Skills	4 years - 6 1/2 years	Yields verbal, performance and full scale deviation IQ's	Psychological Corporation 757 Third Ave. New York, NY 10017
Stanford-Binet Intelligence Scale	Vocabulary, Comprehension Absurdities, Quantitative, Pattern Analysis, Copying, Bead Memory, Memory for Sentences	2 - 18 years	Yields mental age and IQ useful for predicting academic achievement	Riverside Publishing Co. 1919 S Highland Ave. Lombard, IL 60148
Kaufman Assessment Battery for Children (K-ABC)	Sequential processing Simultaneous processing Mental processing Achievement	2 1/2 - 12 years	Yields scores in five areas; norm-referenced/ standardized; Sensitive to minorities; Assesses 5 areas	American Guidance Svcs., Inc. Publishers Bldg. Circle Pines, MN 55014
Leiter International Performance Scale and the Arthur Adaption	Generalization Discrimination Analogies Sequencing Pattern Completion	2 - 18 years	Yields mental age and IQ; Measures intelligence through nonverbal, block pattern-matching response; Assesses 5 areas	Western Psychological Services 12031 Wilshire Ave. Los Angeles, CA 90025
McCarthy Scales of Children's Abilities	Verbal Perceptual-performance Quantitative Motor memory	2 1/2 - 8 years	Yields mental age, standard score, and percentile;. Determines general intellectual levels, strengths, and weaknesses; Norm-referenced/ standardized	Psychological Corporation 757 Third Blvd. New York, NY 10017
Battelle Developmental Inventory	Personal-social Adaptive Motor Communication Cognitive	birth - 8 years	Nationally standardized; Yields age equivalent scores standard scores; Determines relative developmental strengths and weaknesses; Assesses 5 areas; Spanish version available	Riverside Publishing Company 8420 Bryn Mawr Avenue Chicago, IL 60631
Griffiths Mental Developmental Scales	Locomotor Personal-social Learning & Speech Eye & hand performance Practical reasoning	birth - 2 years 2 - 8 years	Offers an infant and a preschool scale; Standard scores in developmental areas and a total score	High Wycomb England

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APPENDIX A-C (continued)

Behavioral/Social Emotional

Assessment Instrument	Domains	Age	Description	Publisher
Vineland Adaptive Behavior Scales,	Self-help Self-direction Occupation Communication Locomotion Socialization	birth - adult	Assesses progress toward social-maturity, competence or independence; Interview format; Yields social age, social quotient; Assesses 6 areas	American Guidance Svcs., Inc. Publishers Bldg Circle Pines, MN 55014
Burk's Behavior Rating Scale	18 categories of behavior	birth - 6 years	Identifies behavior problems and patterns of problems shown by children; Standardized; Assesses 18 categories of behavior	Western Psychological Services 12031 Wilshire Blvd Los Angeles, CA 90025
Topeka Association for Retarded Citizens Assessment Instrument for Severely Handicapped Children (TARC)	Self-help Motor Communication Social	3 - 16 years	Measures adaptive behavior; Appropriate for the more severely disabled; Assesses 4 areas	II & II Enterprises Box 3342 Lawrence, KS 66044
AAMD Adaptive Behavior Scale	13 categories of behavior	birth - adult	Measures adaptive behaviors; Assesses 13 areas of behavior	Edmark Corp PO Box 3903 Bellevue, WA 98009-3503
Balthazer Scales of Adaptive Behavior	Self-help Adaptive and coping behavior	5 - adult	Measures adaptive behavior; Assesses 6 areas of behavior	Research Press Co CFS Box 3327 Champaigne, IL 61820

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APPENDIX A-C (continued)

Communication

Assessment Instrument	Domain / Components	Age	Description	Publisher
Receptive Expressive Emergent Language Scale (REFEL)	Receptive, expressive language	birth - 3 years	Standardized test that yields 3 scores: expressive, receptive and combined	Paul H. Brookes PO Box 10624 Baltimore, MD 21285-0634
Test of Language Development (TOLD)	Receptive, expressive language	4 - 8 years	Standardized test that yields language age, percentiles, subtest standard scores	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Language Development Scale (LDS)	Receptive, expressive language	birth - 60 months	Standardized test that yields language age equivalent; Appropriate for hearing impairment	Ski Hi Outreach Utah State University Logan, UT 84322
Peabody Picture Vocabulary Test Revised (PPVT)	Receptive language	2 1/2 - 40 years	Standardized test that yields a standard score and age equivalents	American Guidance Service Publisher's Bldg Circle Pines, MN 55014
Clinical Evaluation of Language Fundamentals - Revised (CELF-R)	Oral expression	K - 12	Standardized test that yields age equivalents and percentiles	Psychological Corp 757 Third Ave New York, NY 10017
Carrow Elicited Language Inventory (CELI)	Oral expression	3.0 - 7.11 years	Standardized test that assesses language problems	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Preschool Language Scale	Verbal ability Auditory comprehensive Language	1 - 7 years	Evaluates strengths and deficiencies in each area; Provides "language age" description of performance; Spanish version available	Charles E. Merrill Publ. 1300 Alum Creek Drive Columbus, OH 43216

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APPENDIX A-C (continued)

Listening Comprehension

Assessment Instrument	Domains/ Components	Age	Description	Publisher
Test of Auditory Comprehension of Language (TACL-R)	Receptive language	3.0 - 9.11 years	Standardized; Assesses auditory comprehension of language	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Test of Early Language Development (TELD)	Receptive language	3.0 - 7.11 years	Standardized; Assesses language content, form and development; Yields language quotients and ages	Riverside Publishing Co. 8420 Bryn Mawr Avenue Chicago, IL 60631
Boehm Test of Basic Concepts - Preschool Version	Basic concepts Understanding	K - 2	Assesses child's beginning school knowledge of basic concepts	Psychological Corporation 757 Third Ave New York, NY 10017
Boehm Test of Basic Concepts - Revised	Basic concepts Understanding	3 - 5 years	Assesses child's knowledge of concepts	Psychological Corporation 757 Third Ave New York, NY 10017

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APPENDIX A-C (continued)

Criterion-Referenced Instruments

Assessment Instrument	Domains/ Concepts	Age	Publisher
Learning Accomplishment Profile	Fine & Gross Motor, Language Cognition, Self - help, Personal-Social	birth - 72 months	Kaplan Press 600 Jonestown Road Winston - Salem, NC 27108
The Portage Curriculum	Infant stimulation, Socialization, Language, Self-help, Cognitive Motor	birth - 72 months	Portage Project 412 East Slifer Street Portage, WI 53901
Preschool Developmental Profile	Cognition, Perceptual-Fine Motor, Gross Motor, Social-emotional, Self-care, Language	3 - 6 years	U of Michigan Press Ann Arbor, MI 48109
Carolina Curriculum for Preschoolers with Special Needs	Cognition, Communication, Social skills-Adaptation, Self-help, Fine and Gross Motor	2 1/2 - 5 years	Paul Brookes Publishers P O Box 10624 Baltimore, MD 21285
Uniform Performance Assessment System	Preacademic/Fine Motor, Communication, Self-help/Social, Gross Motor, Inappropriate Behaviors	birth - 72 months	Charles Merrill Publishers 1300 Alum Creek Drive Columbus, OH 43216
Oregon Project for Visually Impaired and Blind	Fine-Gross Motor, Communication, Social-emotional, Self-help, Cognition	birth - 72 months	Jackson Co Ed Service District 101 N Grape Street Medford, OR 97501
Individualized Assessment & Treatment for Autistic and Developmentally Delayed Children	Integrated Assessment and Curricular Objectives	birth - 8 years	Pro-Ed 5341 Industrial Oaks Austin, TX 78735
Help for Special Preschoolers	Cognition, Language, Gross & Fine Motor, Social-emotional, Self-help	3 - 6 years	VORT Corporation PO Box 11132 Palo Alto, CA 94306
The Callier-Azusa Scale: Assessment of Deaf/Blind Children	Motor Development, Perceptual Development, Daily Living Skills, Cognition, Communication & Language, Social Development	birth - 9 years	Callier Center for Communication Disorders U of Texas 1966 Inwood Road Dallas, TX 75235
The H/COMP Preschool Curriculum	Communication, Own-Care, Motor, Problem Solving	birth - 60 months	Charles Merrill Publishers 1330 Alum Creek Drive Columbus, OH 43216
The Programmed Environments Curriculum	Functional Living Skills, Cognitive Skills, Motor Skills, Self-help Skills	birth - 60 months	Charles Merrill Publishers 1330 Alum Creek Drive Columbus, OH 43216
Brigance Diagnostic Inventory of Early Development	Pre-speech, General Knowledge, Comprehension, Fine motor, Pre-ambulatory	birth - 7 years	Curriculum Associates North Billeria, MA

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Assessment Instrument	Domains/ Concepts	Age	Publisher
Peabody Developmental Motor Scales	Neuromotor Fine Motor; grasping, hand use, eye-hand coordination, manual dexterity Gross motor; reflexes balance nonlocomotor, receipt, propulsion of objects	birth - 83 months	Riverside Publishing Company 8420 Bryn Mawr Avenue Chicago, IL 60631
Evaluation & Programming System for Infants & Young Children (Gentry & Bricker)	Sensorimotor Skills; Physical Development, Gross & Fine Motor; Social, Self-care; Communication	birth - 2 years	Dept of Special Education U of Idaho Moscow, ID
Play Assessment Scale - R. Fewell, 1986	Toy Play	birth - 4 years	College of Education U of Washington Seattle, WA
Functional Vision Inventory for the Multiple & Severely Handicapped (M.B.Langley)	Functional Vision	All ages	Stoelting Co 1350 S Kosten Avenue Chicago, IL 60623
The Integrated Preschool Curriculum (Odom, et al, 1987)	Social Interaction	birth - 5 years	U of Washington Press U of Washington Seattle, WA
Pre-Feeding Skills (Evans-Morris & Klein, 1987)	Oral Motor Development/Feeding	birth - 5 years	Therapy Skill Building 3830 E Bellevue P O Box 42050 Tuscon, AZ 85733
Transdisciplinary Play-Based Assessment (Toni W. Linder)	Play, Cognition, Social-Emotional Communication, Sensorimotor	birth - 5 years	Paul H. Brookes Co P O Box 10624 Baltimore, MD 21285-0624
Assessment in Infancy: Ordinal Scales of Psychological Development (I. Uzgiris & I. M. Hunt)	Cognition	birth - 24 months	U of Illinois Press Urbana, IL
A Clinical & Educational Manual for Use with the Uzgiris & Hunt Scales (C. Dunst)	Cognition	birth - 24 months	Pro-Ed 5341 Industrial Oaks Blvd Austin TX 78735

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APPENDIX A-D

Types of Test Reliability and Validity

Types of reliability include, but are not limited to:

- *Interrater reliability* - the extent to which two raters will get similar results.
- *Test-retest reliability* - the extent to which the test will yield similar results over time.

Information on reliability should be included in the test manual. Levels of .80 or greater are typically considered to be adequate.

Types of validity include, but are not limited to:

- *Content validity* - the extent to which the content of the test sufficiently covers the area it purports to measure.
- *Concurrent validity* - the extent to which a test yields the same results with a population of children as another, well-established, test.
- *Predictive validity* - the extent to which the results of a test are predictive of the future performance of a population of children.

Levels of .80 or greater are typically considered to be adequate for concurrent validity and predictive validity. Content validity can be judged by a review of the behavior that is measured by an instrument. For example, the content validity of an intelligence test which only measures receptive vocabulary would be questionable, since there is certainly more to intelligence than receptive vocabulary.

APPENDIX A-E

Arena Evaluation

The organization of an arena evaluation is based on the concept of a primary facilitator. One member of the team is designated to serve as primary facilitator by interacting with the child and eliciting the main sample of structured behavior. This does not mean that other team members are forbidden to interact with the child. For example, the physical therapist may need to "lay hands" on the child to assess muscle tone even though another team member is the primary facilitator. It does mean, however, that if there is an instrument or instruments that serve as the more structured part of the evaluation, all team members may need to become proficient at administration. The primary facilitator may be designated as such because the needs of the child best match his or her discipline, because of a relationship established with the child or family, or because of other considerations which may arise. A parent facilitator may also be designated to record parents' input and answer their questions throughout the evaluation. The following has been suggested by Foley (1990) as a possible sequence to follow during the arena evaluation:

Greeting and Warm Up

Family and team members visit, child is allowed to explore and get to know team members.

Formal Task-Centered Sequence

The main assessment instrument is administered by the primary facilitator. Other team members observe and may score discipline-specific instruments or make clinical notes.

Snack Break and Refueling

Snack and bathroom break provides an opportunity to observe self-help skills and parent-child interaction.

Story Time and Teaching Samples

A story time format may be used to expand the language sample or a brief teaching sequence might be used to observe how the child processes new information and generalizes learning to new materials.

Free Play

The child's spontaneous movement and interaction with toys will be observed. With older children, bringing in a peer at this point may allow observation of social interaction skills as well.

Brief Staffing and Feedback

The team members pause to formulate impressions while the parent facilitator collects the parents' comments about the session. Parents and other team members will then come together to share initial impressions so the parents have some closure and do not go away with undue anxiety. A formal staffing with results of the evaluation will be held at a later time.

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Whether or not formal evaluation instruments are used, the advantages of the arena evaluation method described above are many. The evaluation is conducted in an environment where the child feels comfortable with a primary facilitator who has established rapport with the child. The sequence of evaluation tasks and activities is flexible and can be made to fit the pace and interests of the child. The parent can remain with the child to reduce anxiety and facilitate the child's involvements and motivation. The professional members of the team will witness the same sampling of child behavior, each adding expertise from his/her discipline to build a holistic impression of the child's development.

Appendix C includes a list of instruments commonly used in evaluation and assessment of infants, toddlers and preschoolers. Most of these instruments can be utilized in the arena evaluation format.